STATE OF OHIO)
) SS:
COUNTY OF LORAIN)

IN THE COURT OF COMMON PLEAS

NANCY DUNHAM, et al.,

Plaintiffs,

vs. NO. 97CV119540

MANHAL A. GHANMA, M.D.,

Defendant.

DEPOSITION OF:	Richard J. Friedman, M.D.
DATE:	July 13, 1999
TIME:	1:00 PM
LOCATION:	Hood Law Firm 172 Meeting Street Charleston, SC
TAKEN BY:	Counsel for the Plaintiff
REPORTED BY:	Janice N. Shepherd, Registered Professional Reporter

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(INDEX AT REAR OF TRANSCRIPT)

RICHARD J. FRIEDMAN, M.D.

being first duly sworn, testified as follows:

EXAMINATION

BY MR. MISHKIND:

Q. Let the record reflect that we are here in Charleston, South Carolina, on July 13, 1999, for purposes of conducting the discovery deposition of Dr. Friedman who has been identified as an expert to be called on behalf of Dr. Ghanma in the trial of this case. Would you please start out by stating your full name for the record?

A. Richard Joel Friedman.

Q. And you are a physician; is that correct?

A. Yes.

Q. Dr. Friedman, it is my understanding that you have been retained by Mr. Travis on behalf of Dr. Ghanma to testify on his behalf. Is my understanding correct?

A. Yes.

Q. Now, I have -- and you will be testifying, by the way, at the trial which is scheduled in October up in northeastern Ohio?

A. Yes.

Q. Have arrangements been made for you to come *to* Ohio for purposes of your testimony?

A. No.

MR. TRAVIS: Howard, we've got to talk about setting aside time for your doctor and my doctor, but we will be making arrangements. I wanted to talk to you to see if we can agree as to a certain date that the doctor will testify.

MR. MISHKIND: We can deal with that off the record.

BY MR. MISHKIND:

Q. However, my question to you is, you are aware of the trial, and your intent is to come to northeastern Ohio to testify in person; is that correct?

A. Yes.

Q. Now, I have a report that you wrote dated March 17, 1999. Do you have your report there as well?

A. Yes.

Q. Have you written any other letters or reports to Mr. Travis in connection with this case?

A. No.

Q. Have you written any other letters to Mr. Travis at all in connection with this case?

A. No.

Q. Did you prepare a draft of that letter

before you finalized it.

(This page contains information to be supplied by counsel and/or the deponent.)

A. No.

Q. I also have been provided with a copy of your CV. My copy is 63 pages, is dated October 9, 1998. Would there need to be any changes made on that to bring it up to date?

A. Yes.

Q. Can you tell me what additions or deletions? Do you want to take a look at it?

A. Probably just some more articles, publications, talks, maybe a grant or two, just continuing on.

Q. Do you -- I'm sorry, I didn't mean to interrupt you.

A. No.

Q. Do you have a copy of your current CV with you?

A. No.

Q. Would you provide a copy of that to Mr. Travis so that he can send me a copy of your current one?

A. Certainly.

Q. Doctor, can you tell me whether there are

any articles or publications in your CV that are relevant to the opinions that you hold in connection with the care provided by Dr. Ghanma of Mrs. Dunham in this case?

A. What do you mean by relevant to my opinion?

Q. Are there any articles that you have written that deal with the use of hemiarthroplasty in the treatment of three- or four-part proximal humeral fractures?

A. Yes.

Q. Are there any that deal with the success of hemiarthroplasty and the treatment of three- or four-part fractures?

A. I believe that there are some articles that mention that. There is not a specific series examining a specific group of patients and their outcome.

Q. The first question you answered affirmatively, that there are articles that deal with the use of hemiarthroplasty in the treatment of proximal humeral fractures, correct?

A. Yes.

Q. Could you quickly take a look at your CV and perhaps even circle on the CV the numbers?

A. Number 95 and what would be 115. Some of the numbers didn't come out.

MR. TRAVIS: Number 95 on which page, Doctor?

THE WITNESS: I'm sorry, page 18, and the one with lead author as Hartsock on page 19. Those would be the two.

BY MR. MISHKIND:

Q. Have you given any presentations or done any research relative to the use of a hemiarthroplasty in the treatment of proximal humeral head fractures?

A. To the best of my recollection, no research, but I've probably given some presentations on that topic, yes.

Q. Would they also be outlined in your CV as well?

A. Yes.

Q. Could you, with the same request, take a look at that and let me know which ones?

A. Number 141 on page 44, 236 on page 52. That's about it.

Q. Are there any articles or presentations that are relevant to any of the issues that you believe to be germane to this case that are either --

that have been submitted --

(The proceedings were interrupted.)

THE WITNESS: Could we take a break for a second?

MR. MISHKIND: Okay.

(Off-the-record conference.)

(This page contains information to be supplied by counsel and/or the deponent.)

BY MR. MISHKIND:

Q. Strike that question. I'll start over. Are there any articles that will be covered in your updated CV or any presentations that you believe to be relevant to any of the issues in the Nancy Dunham versus Dr. Ghanma case?

A. There might be.

Q. When you submit the copy of the CV, would you take a look and circle any additional articles or presentations that you believe to have some relevance to the issues in this case?

A. Sure.

Q. Do you have copies of the presentations which you circled, which would be presentation number 141 and number 236, back at your office?

A. No.

Q. Where would those materials be?

A. They probably don't exist.

Q. Was there material disseminated at the time you gave those presentations?

A. I have to look and see specifically. There might have been for 236. There was not for 141.

Q. Your testimony is that for 236, though, that the material that was disseminated would no longer be available?

A. Correct.

Q. Doctor, are you an American citizen?

A. Yes.

Q. When did you become an American citizen?

A. October '96.

Q. Have you ever been sued for medical malpractice?

MR. TRAVIS: Objection. You can answer.

THE WITNESS: I was named in a suit initially and then dropped a couple of months later.

BY MR. MISHKIND:

Q. How long ago was that case?

MR. TRAVIS: Can I have a continuing objection?

MR. MISHKIND: Sure.

MR. TRAVIS: Go ahead, Doctor.

THE WITNESS: '92, '93, I think.

BY MR. MISHKIND:

Q. Was that here in South Carolina?

A. Yes.

Q. What was the name of the plaintiff in that case?

A. I believe at the time it was Andrea Ross.

Q. Do you recall the subject matter of the procedure?

A. She had a hip replacement.

Q. You're board certified, correct?

A. Yes.

Q. Were you successful in becoming board certified the first time around?

A. Yes.

Q. Both oral and written?

A. Yes.

Q. Have you ever had your license restricted, revoked, suspended, or otherwise drawn into question?

A. No.

Q. Ever had your hospital privileges revoked, suspended, or limited in any way?

A. No.

Q. Have you ever had an application for

hospital privileges denied?

A. No.

Q. What percentage of your professional time is spent in the active clinical practice of medicine?

A. 80 percent, 90 percent.

Q. What do you do with your other professional time?

A. Research, teaching, administrative responsibilities.

Q. Can you describe for me your clinical practice? What does it consist of?

A. Monday mornings I operate. Monday afternoons I see patients. Tuesday mornings I operate. Tuesday afternoons is open for research, teaching, administrative responsibilities. Wednesday I operate all day. Thursday I see patients all day. Fridays I operate in the mornings, and afternoons are open for catch-up, clean-up, some patients, whatever else.

Q. Do you currently do any teaching in any medical schools?

A. Yes.

Q. Which ones?

A. I'm a professor of orthopedic surgery at the Medical University of South Carolina here in

Charleston.

Q. Any other universities?

A. I have an adjunct professorship of bioengineering at Clemson University.

Q. Do you have an engineering degree as well?

A. No.

Q. Can you explain to me how you became an adjunct professor of bioengineering?

A. I've done a lot of research in biomechanics, particularly related to the shoulder, and did a lot of that with the folks at Clemson, amongst other work, and I guess that's where it stemmed from.

Q. Do you know Dr. Stephen Kay?

A. I know who he is. I don't know him personally.

Q. Have you ever met him at any conventions or --

A. I think I may have met him once or twice.

Q. Do you know of Dr. Kay's professional reputation in the area of shoulder or shoulder surgery?

A. I know he has a shoulder practice out in Los Angeles.

Q. Do you know anything about his reputation as a shoulder surgeon?

A. My understanding is he is a very good doctor.

Q. Doctor, would you tell me what journals you refer to when you want reliable studies in the treatment of proximal humeral fractures?

A. I don't rely or refer to any specific journals.

Q. What journals or studies do you look to for reliable information dealing with the success or complications associated with hemiarthroplasties?

MR. TRAVIS: Objection, since you really haven't defined reliable. You can answer, Doctor.

THE WITNESS: I don't rely on any specific journals, articles, or books.

BY MR. MISHKIND:

Q. I'm not suggesting you rely on any specific ones. But if you wanted any information on recent studies concerning complications following hemiarthroplasty, where would Dr. Friedman look first for studies dealing with complications and treatment following hemiarthroplasty?

A. Probably the computer, do a literature search and find out what has been published over the

last two, three, five years, whatever period I was looking at, and find out who has published articles on that topic.

Q. Have you for purposes of this case done any medical research?

A. No.

Q. Do you intend to take the stand and indicate that any particular article or any particular study is authoritative in connection with the issue of the treatment of post hemiarthroplasty complications?

A. No.

Q. Are you familiar with the article that Dr. Kay wrote on hemiarthroplasties?

A. Yes.

Q. Have you read that article?

A. I have read it in the past and reviewed it before with Mr. Travis.

Q. And do you consider it to be a well-written article on the topic?

MR. TRAVIS: Objection, if you understand what well-written means.

THE WITNESS: I think it's a small number of patients, different diagnoses, different prostheses used, and I think it's difficult to draw

any definitive conclusions from that. It's more just a descriptive paper indicating how their 15 patients did.

BY MR. MISHKIND:

Q. Are you aware of any articles or can you cite me to any articles that talk about the success of a secondary surgery following a failed original hemiarthroplasty for a patient who had a traumatic proximal humeral head fracture?

A. Not off the top of my head, no.

Q. You haven't written anything that talks about the success of secondary surgeries in that setting, have you?

A. No.

Q. Have you served as an expert witness before this case?

A. Yes.

Q. On how many occasions?

A. I couldn't tell you because I don't keep records. I don't count, so I don't have an accurate number.

Q. It's obviously more than a couple; otherwise, you'd be able to say to me this is the second time or the third time. So let me ask you in sort of a ball park, are we talking more than ten

times?

A. Probably more than ten times.

Q. Are we talking more than 100?

A. Again, I'd just be guessing. I don't know.

Q. More than 20 times?

A. Again, I'd just be guessing. I don't know.

Q. Where do you keep records concerning your prior cases that you served as an expert witness?

A. Don't keep records.

Q. What do you intend to do with these records following this case?

A. Throw them out.

Q. Where do you maintain these records currently, other than right in front of you?

A. My house.

Q. Is that where you keep your records for medical malpractice cases?

A. Yes.

Q. How many cases are you currently reviewing as an expert witness?

A. I don't know. I don't count.

Q. More than just this case?

A. For medical malpractice? Yes.

Q. More than a half a dozen cases that you're currently reviewing?

A. Again, I haven't counted, so I couldn't tell you.

Q. You've been deposed before, haven't you?

A. Yes.

Q. And you've been asked this question before, haven't you?

A. Yes.

Q. And having been asked this question before, did you ever stop and think you might want to be able to respond in terms of numbers?

A. Actually, I've stopped and thought about it and decided I don't want to respond to numbers.

Q. Your address is 33 -- is it Rebellion Road?

A. Yes.

Q. Is that your home address?

A. Yes.

Q. Where is your office located?

A. 171 Ashley Avenue.

Q. Is that a medical building?

A. It's the Medical University Hospital.

Q. I'm sorry?

A. It's the Medical University Hospital.

Q. Is that where you see patients on an outpatient basis?

A. No, we have two facilities. One is a few blocks away, and one is a couple of miles away.

Q. Where do you see your patients, or does it vary between the two offices on an outpatient basis?

A. Monday afternoons it's up in North Charleston, and all day Thursdays it's at the building three blocks away from the hospital.

Q. Do you have partners in your practice?

A. Yes.

Q. Who are the doctors?

A. Dr. Angus McBryde, Dr. Langdon Hartsock, Dr. Del Schutte, Dr. Keith Merrill, Dr. John McFadden, Dr. David Tate, Dr. Dick Gross, Dr. Carl Stanitski, Dr. Debbie Stanitski. I think that's it.

Q. Is there a reason that your letter is written on personal stationery as opposed to professional stationery?

A. This is something separate from my practice at the hospital. I keep it separate.

Q. And what percentage of your time would you say that you devote to serving as a medical witness?

A. Again, I've never figured numbers, but it's obviously small to tell you -- to outline to you. I have a busy practice during the week. There's only so many hours in the day.

Q. You can't answer that question?

A. Other than how I have, no.

Q. How many years have you been serving as an expert witness?

A. I think the first time I got asked -- I don't remember exactly the case. Early '90s.

Q. How many cases do you review on average in any given year?

A. Again, I don't know because I don't count. I don't keep track.

Q. Are we talking a half a dozen, or are we talking close to 20 cases?

A. Again, I don't count. I don't have accurate numbers. I'm not going to guess.

Q. Can you give me an estimate?

A. No.

Q. Do you review more than two or three cases a year?

A. Yes.

Q. Do you review more than six cases a year, one every two months?

A. Probably, yes.

Q. Do you review more than one case a month?

A. Again, I don't know.

Q. How many times have you testified in this type of a setting, in a deposition as opposed to in the courtroom?

A. Again, I don't keep track. I don't count, so I couldn't answer that.

Q. You've been doing this since the early '90s, if we use that sort of as a landmark?

A. As I said, I think the first time I was asked to review a case as an expert was the early '90s. I don't remember if that went to deposition or not.

Q. Let's just take the predicate that you haven't been doing this any longer than eight or nine years. Is that a fair statement?

A. Seven, eight years.

Q. And do you testify by way of deposition more than once a year?

MR. TRAVIS: Can I have a clarification? Are you talking about cases where a patient is injured --

MR. MISHKIND: I'm talking about medical malpractice cases.

THE WITNESS: Sometimes it's less than once a year. Sometimes it's more than once a year. It varies.

BY MR. MISHKIND:

Q. When was the last time you were deposed in a medical malpractice case?

A. I think it was February, March of this year.

Q. What was the name of that case?

A. I think Butler was the patient.

Q. What state?

A. South Carolina.

Q. Who was the doctor?

A. Woodward.

Q. Spell the last name, please.

A. Woodward.

Q. Down here in Charleston?

A. The doctor was from Columbia. The deposition took place down here in Charleston.

Q. When are you next scheduled to give deposition testimony in a case?

A. A malpractice case?

Q. Yes.

A. I think I've got a deposition in August or September for a case in Florida.

Q. What's the name of that case?

A. I think it's Hiney versus Alter, H-I-N-E-Y.

Q. Are you the expert for the patient or the expert for the doctor?

A. In both of those, I was for the defense.

Q. Do you recall the name of the attorneys or any of the attorneys in those cases?

A. Yeah, I should know the guy's name up in Columbia. The firm is Richardson, Plowden. George Beighley was the attorney up in Columbia. I can't remember the attorney in Florida.

Q. Is Mr. Beighley the attorney for the doctor?

A. Yes. That case was settled a couple of months ago.

Q. Did either of those cases involve shoulder surgery?

A. The one in Columbia did not. The one in Florida does.

Q. What part of the state of Florida did the surgery take place in?

A. I don't recall, but the lawyer is based in Orlando.

MR. TRAVIS: Just answer the question.

BY MR. MISHKIND:

Q. Were both lawyers from Orlando, Florida, plaintiff's and the doctor's lawyer?

A. I don't recall.

Q. That case did involve a shoulder surgery?

A. Yes.

Q. Did it have -- was it a hemiarthroplasty?

A. I can't recall the specifics of it.

Q. How many times have you testified, Doctor, actually in a courtroom as an expert witness in a medical malpractice case?

A. To the best of my recollection, four or five -- in medical malpractice?

Q. Yes.

A. Three or four times, if I can remember.

Q. When is the last time you testified in a courtroom in a medical malpractice case?

A. Last fall.

Q. Where?

A. Orlando.

Q. What was the name of that case?

A. I don't remember.

Q. Who was the attorney or the name of one of the attorneys that was involved in that case?

A. The attorney I remember was Mr. Richards

Ford.

Q. Richards was his first name?

A. Yes.

Q. And were you testifying on behalf of the patient or on behalf of the doctor?

A. For the defendant, the doctor.

Q. Aside from medical malpractice cases, do you serve as an expert witness in connection with other orthopedic matters?

A. What do you mean by other orthopedic matters?

Q. Non-medical malpractice matters, injury cases.

A. Yes, and I've been involved in one patent infringement lawsuit.

Q. Okay. How frequently are you asked to give testimony as an orthopedic surgeon in connection with injury-related cases?

A. Not very frequently.

Q. Do you do what's known as independent medical examinations?

A. Occasionally do those in the office, yes.

Q. When you say occasionally, how frequently do you do them?

A. Less than one a week.

Q. How many different insurance companies do you do work for in connection with these independent medical exams?

A. Don't really know. I mean, a lot of times they call and make an appointment. It's all done through scheduling, and I just see the patient and render an opinion. I don't know where it's coming from,

Q. Do you know the names of any of the insurance companies that you do work for?

A. A lot of times the patients come with rehab nurses, so I may not be aware of the companies. But to mind, I think Allstate and State Farm.

Q. By the way, who is your medical malpractice carrier?

MR. TRAVIS: Objection. You can answer.

THE WITNESS: We're insured by the State of South Carolina.

BY MR. MISHKIND:

Q. It's not an independent company?

A. No.

Q. Doctor, in terms of the work that you do as a witness in medical malpractice cases, what percentage of the time have you given testimony on behalf of the patient, and what percentage of the

time on behalf of the doctor being sued?

A. For testimony, it's probably -- maybe 60/40, 70/30 for defense.

Q. And you've been asked that question before by other attorneys, correct?

A. Yes.

Q. And in terms of review of cases, how would you define the breakdown between plaintiff and defendant?

A. My impression is probably 50/50.

Q. And, again, that question has been asked of you as well in the past, correct?

A. I believe so, yes.

Q. And have the numbers changed in terms of the percentages in the last year or two?

A. My impression is a little more for the defense, yes.

Q. Have you ever testified in a case similar to Nancy Dunham where there was a complication following a hemiarthroplasty?

A. No.

Q. Doctor, do you provide your name to any companies that locate expert witnesses for attorneys?

A. One company.

Q. What's the name of that company?

A. Dr. Stephen Learner & Associates.

Q. And how long have you provided your name through Dr. Learner's company?

A. Three years.

Q. Any other companies that you provide your name through?

A. No.

Q. Have you in the past provided your name through any other expert search firms or expert witness companies?

A. No.

Q. Have you ever advertised independently in any publications your availability as an expert witness in medical malpractice cases?

A. No.

Q. When were you first contacted by Mr. Travis?

A. I believe in February of this year.

Q. There's a letter that's in front of you. By the way, do you have all of your correspondence that Mr. Travis has sent to you?

A. I believe so, yes.

Q. You said that you maintain this material at your home, correct?

A. Yes.

Q. And when the material was sent to you by Mr. Travis, it was sent to you at your home, not at your offices, correct?

A. Correct.

Q. Is there anything that relates to Nancy Dunham back at your home that you didn't bring with you today?

A. No.

Q. Was there anything that was removed by Mr. Travis that was in the material that is in front of you today before this deposition started?

A. No.

Q. So all of the correspondence that you have, that you've received from Mr. Travis, is in front of you?

A. Oh, I think I threw out a cover letter that came with a check covering this deposition. Other than that, everything I've been sent is here.

Q. How is it that Mr. Travis obtained your name? Was it through Stephen Learner & Associates?

A. No.

Q. How did he obtain your name?

A. I don't know.

Q. What did he indicate to you when he called you?

A. I believe he asked me if I'd review a case, gave me the specifics -- some of the specifics, and I said, okay and told him where to send the materials.

Q. And did you make any notation of that conversation anywhere?

A. No.

Q. Since you provide your service through this company, I presume you asked him how it was that he obtained your name?

A. No, actually, I didn't.

Q. Do you have any knowledge as to how he obtained your name?

A. No, I don't.

Q. Even as you sit here now, did you ever ask him how you happened to come upon me?

A. I don't know how he got my name.

Q. Now, what was it specifically that Mr. Travis asked you to do in connection with this case?

A. To the best of my recollection, he asked me if I'd review the records and offer an opinion as to whether Dr. Ghanma deviated or violated from the standard of care.

Q. How would you define that term, standard

of care?

A. I would define that as what one would expect from an average orthopedic surgeon practicing.

Q. I don't see in any of the correspondence any specific issues identified by Mr. Travis in the letters. Did you make any notation when you were reviewing the case of any of the specific issues that he was looking for you to address?

A. I made some notations. They weren't necessarily anything that he asked specifically, I sometimes just jot some points down as I'm going along that I wonder about or need to look up after that may or may not get answered.

Q. I notice on the back of several of the letters that you have some handwritten entries. Are those in your handwriting?

A. Yes.

Q. Are there other notes that you made that you have since discarded?

A. No.

Q. So everything that you have written down you have with you today?

A. Yes.

Q. When you prepared the report, did you type it yourself?

A. Yes.

Q. Did you do it on a computer?

A. Yes.

Q. Was this a work in progress as you were reviewing the material?

A. I'm not sure what you mean.

Q. Did you just sit down one day and compose the letter, or did you compose it as you were reviewing the material?

A. I sat down one day and composed the letter.

Q. Can we agree, Doctor, that the vast majority of three- or four-part fractures, the humeral component is secured with cement to achieve stability?

A. In the majority of cases, I would say that's correct, although there are certainly people who talk about using a press fit technique and not using cement.

Q. And you're looking actually to achieve what's known as rotational stability, correct?

A. That's one type, yes.

Q. The type of surgery that Dr. Ghanma did in this case, is this the type of surgery that you use in approaching a three- or four-part fracture in

a patient that is 66 years old with the medical history that Mrs. Dunham had?

A. Yes.

Q. You would have approached the surgery in terms of the same operative technique?

A. Similar, yes.

Q. How would it have differed?

A. I may have cemented the prosthesis. That's a judgment you make at the time, if you think it's stable enough. If it's stable, it's perfectly okay to press fit it. If it's not stable, then you'd cement it.

Q. How many hemiarthroplasties do you perform during any given year?

A. Again, I don't count or keep track, but we do -- are you talking about for fractures?

Q. Yes.

A. Probably a rough guesstimate, one a month, maybe a little more.

Q. Now, you said we. I'm talking about you personally.

A. One a month.

Q. Would you describe what Dr. Ghanma did as a Neer-type hemiarthroplasty?

A. Okay, yes.

Q. Well, I don't -- if I'm not using the proper reference, then correct me. Don't agree with me just to be cooperative.

A. No, I think that's an okay description.

Q. The one per month that you do in terms of hemiarthroplasties for fractures, how long have you been doing on average one a month?

A. I would say a number of years, but I can't give you a specific number.

Q. Before the 1990s, or is it just in the 1990s?

A. Probably the 1990s. I mean, I started practicing in '86, and obviously volume grows as time goes on.

Q. How about the number of hemiarthroplasties that you do for three- or four-part fractures, or is that the same one?

A. It's the same thing.

Q. Okay. In fact, if it was less than a three-part, you wouldn't necessarily be doing a hemiarthroplasty, would you?

A. Correct, and for some three-parts, we treat them differently.

Q. And some are actually treated in a conservative manner without surgical intervention,

correct?

A. Correct.

Q. By the way, I asked you how you were introduced to Mr. Travis, and you can't tell me how that was. Can you tell me whether you are reviewing any other cases for him or anyone at his law firm of Gallagher, Sharp?

A. I don't believe so.

Q. Have you at any time done any work for any other attorneys at the Gallagher, Sharp law firm?

A. I don't believe so.

Q. Have you ever reviewed a case for any attorneys up in the Cleveland, Ohio, area, other than Mr. Travis?

A. I may have, but I can't remember specifically.

Q. What about in the state of Ohio?

A. I may have. I can't remember specifically.

Q. If you wanted to know who you've worked with, do you maintain any type of record on a case, or do you, once you're done with a case, just dispose of the material and forget about it?

A. Dispose of the material and forget about it.

Q. And just wash your memory of any contact with that lawyer or the case or the location?

A. That's correct.

Q. So I guess the only records we would have relative to your involvement would be payment records that you receive for services in connection with the cases, correct?

A. Correct.

Q. Because, obviously, you've got to report that as income in your taxes?

A. I report all the 1099s that are sent to me, that's correct.

Q. Let me see the correspondence. You have a notebook, Doctor, black notebook that has a number of items, and I believe that the items include Dr. Ghanma's office chart, Elyria Memorial Hospital records, Cleveland Clinic Foundation records, and then records from a Dr. Viswanath and a Dr. Carandang, and CVC Pharmacy records. Is that correct?

A. Yes.

Q. You also received the deposition of Dr. Ghanma and Mr. And Mrs. Dunham?

A. Yes.

Q. And apparently just recently you received

the deposition of Dr. Kay?

A. Yes.

Q. Have you read Dr. Kay's deposition?

A. Yes.

Q. Other than the x-rays, have you received and reviewed any other information in connection with this case?

A. No.

Q. Now, contained in the Cleveland Clinic records are Dr. Brems' records and his letter that he wrote to Dr. Ghanma, correct?

A. It's in here, yes.

Q. Do you know Dr. Brems?

A. Yes.

Q. How do you know Dr. Brems?

A. Professionally, we met at meetings, talked to each other.

Q. Have you ever had an opportunity to talk to Dr. Brems concerning this case?

A. No.

Q. By the way, have you ever talked to or met Dr. Ghanma?

A. No.

(PLF. EXH. 1, 2/4/99 Letter to Dr. Friedman From D. John Travis, was marked

for identification.)

(PLF. EXH. 2, 2/22/99 Letter to Dr. Friedman From D. John Travis, was marked for identification.)

(PLF. EXH. 3, 6/22/99 Letter to Dr. Friedman From D. John Travis, was marked for identification.)

BY MR. MISHKIND:

Q. Doctor, I've marked for identification three letters to you from Mr. Travis dated February 4, February 22nd, and June 22nd, 1999, respectively. And on the back of each of these letters is handwriting by you, correct?

A. Yes.

Q. When did you make theses notes?

A. They would have been the time I was reviewing the records, as I reviewed them.

Q. On the back of this February 22nd note, a letter, you have notes from your read of the Dunham and Ghanma depositions, correct?

A. Correct.

Q. And is this one page all that you marked down when you read through those three depositions?

A. As you've asked that, I've already answered, this is all that I have.

Q. Again, I want to make sure as I'm looking at your notes now. This is the one and only page of notes that you made as you read over the depositions of those three individuals?

A. Yes, the two.

MR. TRAVIS: You said two?

THE WITNESS: The Dunhams and Dr. Ghanma.

BY MR. MISHKIND:

Q. And then at the very bottom, you have a note here, 3 3/4, plus report 1 1/41 which equals five hours, plus talk, 1/4, equals 5 1/4 hours. I assume that's for billing purposes?

A. Yes.

Q. What did you bill -- or what have you billed Mr. Travis on an hourly basis for your review in this case?

A. Again, I charge -- I bill $500 an hour. I don't keep track of the total. He would have that. But, obviously, for all that, it came to 5 1/4 times 500.

Q. And then this letter of June 22nd, you have notes on the back of that letter which I presume relate to your read of Dr. Kay's deposition?

A. Yes.

Q. And, again, is this all that you have

written concerning your review of Dr. Kay's deposition?

A. Yes.

Q. And, again, at the very bottom, you have 1 3/4 hours plus 1/4 hour talk for a total of two hours?

A. Yes.

Q. And that was billed at the rate of $500 an hour?

A. Yes.

Q. Now, at the bottom of this note, it says, tell Travis about my two BA something. I can't decipher --

A. TSA books.

Q. My two...

A. TSA.

Q. Okay, what is TSA?

A. Total shoulder arthroplasty.

Q. Why did you make that note, tell Travis about my TSA books?

A. To let him know that I wrote two books on shoulder replacements.

Q. And what are the names of those books?

A. One is called *Arthroplasty: The Shoulder.* And the other one is actually an issue of

Orthopedic Clinics of North America that dealt with total shoulder arthroplasty.

Q. Why, when you were reviewing Dr. Kay's deposition, did you make a note to tell Mr. Travis about these two books?

A. Just thought it was relevant, he'd probably want to know about it.

Q. Is there anything in particular in those two books that you felt Mr. Travis should be aware of?

A. No.

Q. You have various people that have contributed different sections to those books, correct?

A. Yes.

Q. And certainly you would consider the contributors to your books to be well-respected and well-regarded orthopedic surgeons?

A. Yes.

Q. And the subject matter of their various sections, you would deem those to be reliable and authoritative?

MR. TRAVIS: Objection. If you understand the question, you can answer.

THE WITNESS: I would deem the authors to

be people who have experience in those areas.

BY MR. MISHKIND:

Q. What about the topics that are covered, do you consider what they have said on the topics to be accurate and reliable?

MR. TRAVIS: I'm going to object unless you present him with a specific article he can comment on. You can answer if you can, Doctor.

THE WITNESS: Again, I think that each article reflects the author's beliefs and opinions at the time that it was written.

BY MR. MISHKIND:

Q. Are you saying there are certain beliefs and opinions by authors in your textbooks that you don't necessarily agree with?

A. No. I think more what I'm saying is that things change over time. So something that may have been written a number of years ago may not necessarily be true today.

Q. I note at the bottom here: M.D. made a reasonable judgment call at the time. Just because it doesn't turn out correct, doesn't equal negligence or deviation.

Did I read that correctly?

A. I believe so, yes.

Q. And you would certainly recognize that simply because you label something as a judgment call, doesn't mean that it isn't necessarily below the standard of care?

A. Would you repeat that?

Q. Sure. If a doctor exercises judgment in approaching something, in your opinion, does that always excuse him from being responsible for having deviated from accepted standards of care?

A. No.

Q. There are judgments that a doctor demonstrates in the treatment of a particular situation that can amount to substandard care or negligence, correct?

A. Yes.

Q. So even though the doctor may have exercised what he considered to be reasonable judgment in a given circumstance, you wouldn't necessarily say to a jury that because he exercised what he considered to be reasonable judgment, that he was therefore free of substandard care?

A. That's correct.

Q. I'm going to talk to you a little bit further about this one when we get to that. In fact, I'm going to have you decipher some of your

handwriting. Some of it I can read, believe it or not. You met with Mr. Travis for approximately two hours before this deposition, correct?

A. Yes.

Q. And what did you and he discuss during that meeting?

A. We just went over some of the facts of the case, went over some of the x-rays. That's about it.

Q. Did Mr. Travis share with you his theory of liability in this case?

MR. TRAVIS: Objection. Are you assuming I have a theory of liability? You can answer if you can.

THE WITNESS: No.

BY MR. MISHKIND:

Q. Did he share with you what the theory is, the plaintiff's theory in this case?

A. No.

Q. When did you first meet Mr. Travis?

A. Approximately 11 a.m. this morning.

Q. Had you met him before 11 a.m. today?

A. No.

Q. You talked to him, obviously, on the phone, but this is the first time you met him in

person?

A. Yes.

Q. Now, your charge today for a deposition is $600 an hour, correct?

A. Correct.

Q. And I believe I was required to pay you an advance payment a certain number of weeks ahead of time in the amount of two hours as an advance payment, correct?

A. Yes.

Q. What is your charge when you come to Cleveland or northeastern Ohio to testify in Lorain County for purposes of this case?

A. It's $600 an hour for a minimum eight hours of one day, which would be 4800, plus expenses.

Q. In the number of hemiarthroplasties that you've done for three- or four-part proximal humeral head fractures, how many have you had where two to three weeks after surgery, the greater tuberosity had avulsed?

A. Are you talking about ones that I did or ones that got referred in to me after they were done?

Q. Ones that you have done.

A. I had one recently, and other than that, I can't think of one where that's happened.

Q. Tell me about that patient.

A. It was a 51-year-old gentleman who was involved in a high speed motor vehicle accident, and he sustained -- I think it was a four-part fracture, amongst numerous other injuries, including a broken neck. We went ahead and did a hemiarthroplasty. And at some point between two weeks and six weeks, he pulled his tuberosities off.

Q. How did you treat that situation?

A. We waited about two months until his neck fracture healed, and then we took him back and reoperated on him.

Q. The determining factor in terms of waiting was the neck fracture?

A. That was a big part of it, yes, and his other overall medical condition and problems.

Q. If he didn't have the neck fracture and other medical problems, I presume associated with the injury, would you have gone back in and operated sooner?

A. Yes.

Q. If a decision is made to do a secondary surgery -- to perform a secondary surgery following a failed hemiarthroplasty, is it better to do the secondary surgery early on as opposed to on a delayed

basis?

A. I think, in general, the earlier you do something, the better the result *is* going to be.

Q. And from the standpoint of the shoulder and treating a failed hemiarthroplasty, why is, as a general rule, better -- why as a general rule is earlier better than waiting?

A. Well, I think that's true for any body part. In the shoulder specifically, the function and outcome is very dependent on the soft tissues, and you get a lot of scarring and healing that occurs as time goes on, which is something you have to deal with. And if you can get to it before that happens, you have a chance of getting a better result.

Q. In the situation with this gentleman where you went in after his neck condition was stabilized and did a secondary repair, did you do another hemiarthroplasty?

A. No, we just went ahead and reattached the tuberosities and the rotator cuff as best as we could.

Q. And how is he doing functionally?

A. He is doing much better now than he was, yes.

Q. In terms of his pain and his limitations

in terms *of* active range of motion, where is he at now?

A. I'm not sure what you mean, where is he at now.

Q. Is he experiencing less pain than he was following the avulsion of the greater tuberosity?

A. Yes.

Q. Is he pain-free?

A. I don't recall if he's pain-free, but he's certainly much less painful than he was.

Q. In terms of the range of motion that he has achieved as a consequence of your doing the secondary repair, does he have increased range of motion over what he had when the greater tuberosity -- the avulsion of the greater tuberosity was discovered?

A. Yes.

Q. Do you know offhand what his range of motion is now?

A. I don't recall.

Q. Would you agree that meticulous surgical technique is essential to prevent complications at the time of a hemiarthroplasty?

A. I think meticulous technique is essential to minimize the complications.

Q. Would you agree that factors that correlate with poor post-op results include tuberosity nonunion and malunion?

A. Yes.

Q. Putting aside your case with the gentleman from the high-speed crash, you said that you've also had patients referred to you where you've gone in and done secondary repairs, correct?

A. Yes.

Q. How many secondary repairs have you done following failed hemiarthroplasties?

A. Again, I can't give you an accurate number, but there have been a number of them.

Q. Again, just so that I have some context, are we talking more than a dozen or less than a dozen?

A. More than a dozen.

Q. More than two dozen?

A. Over the years I've been in practice, I would just be guessing.

Q. So certainly more than a dozen, but you can't be any more specific than that?

A. Correct.

Q. Of those cases, has the success in terms of reduction in pain and increase in range of motion

been greater the earlier that you've gotten in to do the secondary repair following the failed hemiarthroplasty?

A. I haven't reviewed those patients and looked at that specifically, so I can't give you an accurate answer.

Q. The ones that you have done secondary surgery on, have they been trauma cases?

A. Right. We're talking about three- and four-part fractures.

Q. Correct, okay. So you're excluding any avascular necrosis and arthritic cases. You're dealing in the context of trauma?

A. Correct.

Q. Okay, fine. I just want to make sure we're on the same page. The failed hemiarthroplasties, have they been in large part due to avulsion of the greater tuberosity?

A. I think some have been avulsions. Some have been malunions.

Q. Is it sometimes difficult to detect the difference between an avulsion and a malunion of the greater tuberosity?

A. Let me add, some have also been nonunions, so nonunions can be difficult to determine

sometimes. Sometimes the anatomy is very distorted, and it can be difficult to discern exactly what is going on. And some of the usual x-ray tests that we get are not helpful because of the presence of metal. They distort the pictures, such as a CT scan. So you have to make a clinical judgment and then decide a large part while you're in there what needs to be done and do it.

Q. Is it fair to say, though, that if you suspect that there has been either an avulsion of the greater tuberosity or a malunion or a nonunion *of* the greater tuberosity, that the standard of care for an orthopedic surgeon requires consideration of the options that are available to treat that condition?

MR. TRAVIS: Can you read that back, please?

BY MR. MISHKIND:

Q. I'll strike that. The doctor had a quizzical look on his face. Would you believe the standard of care requires that the surgeon recognize as promptly as one can that there has either been an avulsion, malunion, or nonunion of the greater tuberosity?

A. Yes.

Q. And once having recognized that there is

some process going on that is not what had been planned and not what appeared to exist at the time of the surgery, would you agree that the surgeon has to consider the method of treatment, surgical versus conservative?

MR. TRAVIS: Objection, compound question. You can answer if you can.

THE WITNESS: Yes.

BY MR. MISHKIND:

Q. And would you agree that, ultimately, it's the patient that has to make the decision as to whether or not to have surgery or to be treated on a conservative basis?

A. Repeat the question.

(The Court Reporter read the question commencing on page 51, line 10, and concluding on page 51, line 13.)

THE WITNESS: I think the patient ultimately makes the decision, if surgery has been recommended, whether to have it or not, that's correct.

BY MR. MISHKIND:

Q. It's the physician's obligation to explain to the patient first what the condition is, correct?

A. Yes.

Q. And that being a complication that has occurred subsequent to the hemiarthroplasty?

A. Assuming it's occurred, yes.

Q. And then the physician has an obligation to explain to the patient the various methods of treating that complication that has occurred since the time of the hemiarthroplasty, correct?

A. To a certain degree, yes.

Q. And, ultimately, if one of the methods of treatment would include surgery, the physician has to explain the risks and benefits of undergoing surgery to treat a failed hemiarthroplasty, correct?

MR. TRAVIS: Objection to the abstract hypothetical question. You can answer if you can, Doctor.

THE WITNESS: Yes.

BY MR. MISHKIND:

Q. And would you agree that if the physician does not explain to the patient the risks and benefits of undergoing surgery once a failed hemiarthroplasty has been discovered, that that would not be in keeping with accepted standards of care?

A. If the physician is proposing surgical intervention, then I think the standard of care

dictates that he explain what the options of the surgery are, what the risks, the benefits are.

Q. You would certainly agree that the patient is entitled to understand whether or not surgery is an option for the treatment of a failed hemiarthroplasty, correct?

A. If the physician considers it to be an option, yes.

Q. Even though the physician or the surgeon may not necessarily be recommending that, if the physician feels that that is an option, the physician has a duty and obligation to explain what the methods of treatment are and why he's recommending one as opposed to another, correct?

A. Well, it depends if you think it's an option in that patient or it's just an option that exists but wouldn't be applicable in that patient.

Q. No, an option in that particular patient, but the doctor doesn't necessarily recommend it. He certainly still has an obligation to explain the options and why he's recommending one course of treatment as opposed to another, correct?

A. In general, that's correct.

Q. When you reviewed the films -- you had a chance to look at the original films before today's

deposition, correct?

A. Yes.

Q. And, previously, you had seen copies of the films?

A. Yes.

Q. Are any of the opinions that you have in the case altered in any respect after having seen the original films?

A. No.

Q. The original films back in January of 1995 show an avulsion of the greater tuberosity, do they not?

A. They show -- which films are we talking about?

Q. January 3 and January 10, 1995.

A. They show a change in the fragment position compared to the one post-op film that I saw from December the 18th, 1994.

Q. My specific question to you is, do they show that the humeral -- that a bone fragment is present superiorly between the acromion and humeral head consistent with avulsion of a portion of the greater tuberosity?

A. They do show a fragment of bone superior to the humeral prosthesis. Given the fact that the

humeral head is still articulating or matching up properly with the glenoid, then I would have to say it does not involve the major part containing the rotator cuff, because if it did, then I would expect the humeral prosthesis to be riding high, which it's not.

Q. Which film are you looking at?

A. The films of January 3rd, 1995.

Q. Look at the January 10 films, if you would, also.

MR. TRAVIS: Is there a question?

BY MR. MISHKIND:

Q. Do those films show the humeral -- the bone fragment present superiorly between the acromion and the humeral head consistent with avulsion of a portion of the greater tuberosity?

A. They show a piece of bone up there, and it basically does not look to be changed from the films a week earlier.

Q. Are they consistent with an avulsion of a portion of the greater tuberosity?

A. I think they're a piece of the tuberosity bone, I don't think they're a piece containing the major rotator cuff portions.

Q. Again, my question is, are they

consistent with avulsion of a portion of the greater tuberosity?

A. Yes.

Q. And when we refer to an avulsion of the greater tuberosity or a portion of the greater tuberosity, what does that mean?

A. A piece of the bone is pulled off.

Q. Your testimony, however, is that that avulsion of a portion of the greater tuberosity was not a significant part, portion of the greater tuberosity?

A. Correct.

Q. What was causing the avulsion of a portion of the greater tuberosity some two weeks post-op?

A. I'm not sure I understand the question.

Q. Why was there an avulsion of the greater tuberosity that was detected two weeks after Dr. Ghanma's hemiarthroplasty?

A. Well, the piece moved. Again, I don't know if that piece was ever secured down. As he mentions, that there were a number of loose pieces that he did not fix. And it may be that one of those pieces that was not fixed had moved. It would have moved because the patient was doing physical therapy

and moving the shoulder. I can't tell if that was one of those pieces or if it was a piece that was secured down at the time of surgery and then moved off.

Q. Your testimony, though, is that is not a significant portion of the greater tuberosity?

A. Correct.

Q. And why do you say that?

A. Because if it was, then he would have no cuff left attached -- sorry, she would have no cuff left attached. The humeral head would rise up against the face of the glenoid. And, clinically, it would correlate -- the x-ray finding would correlate with the clinical picture, which it does not.

Q. If this is a significant portion of the greater tuberosity and it's discovered within a two-week period following surgery, following Dr. Ghanma's surgery, which was done in December of 1994, would you agree that secondary surgery to correct a significant portion of the greater tuberosity should have been considered at that point?

MR. TRAVIS: Objection to the question as stated. You can answer if you can.

THE WITNESS: Again, I think you have to look at the patient. Remember, we treat patients.

We don't treat x-rays. I think you have to correlate the radiographic findings with the patient's symptoms and physical findings. Take all that into account, plus the findings that you notice at the time of the surgery to decide whether further surgery would be indicated or not.

BY MR. MISHKIND:

Q. Well, let me try to give it to you a little bit differently perhaps to try to get a more exact answer from you. You do a hemiarthroplasty on a patient for a three- or four-part fracture. By the way, do you consider this a three- or four-part?

A. I think it was probably more three-part.

Q. You do a hemiarthroplasty for a three-part proximal humeral head fracture. Assume that the patient within a two-, three-week period demonstrates radiographically an avulsion of a significant portion of the greater tuberosity. Further assume that the patient is symptomatic pain-wise and does not -- is not getting the kind of range of motion back that you would want two to three weeks following your hemiarthroplasty. Under those circumstances, hypothetically speaking, would you agree that surgery should be considered to correct this problem?

MR. TRAVIS: Objection to the hypothetical. You can answer if you can.

THE WITNESS: That's a lot of hypotheticals. But 1 think if you have the scenario that the patient was progressing along at a certain pace and then something changed very suddenly and they had lost the function that they had and they were having significantly more pain than they had and you had those radiographic findings, in a hypothetical situation, then, yes, I would consider surgical intervention.

BY MR. MISHKIND:

Q. So each case in terms of whether you want to recommend secondary repair is going to depend upon what has developed from the time *of* the surgery up until the time that that avulsion of the greater tuberosity has been discovered. Is that a fair statement?

A. It's going to depend on that, plus also the condition of the bone and the soft tissues that you notice at the time of your initial surgery.

Q. Okay, Well, in terms of your article that you did with Dr. Langdon and Hartsock and those guys, you reviewed the success of total shoulder arthroplasty in what you considered to be patients

over 70 and patients under 70, didn't you?

A. I'd have to take a look at it. May I?

Q. You don't recall?

A. I don't recall that specifically, no.

Q. Okay. Would you agree that Mrs. Dunham's age being less than 70 is a good factor in terms of the probability of achieving a good functional outcome?

A. I don't consider there to be a difference between a 66-year-old and a 70-year-old in that case.

Q. You're familiar with Goldman and his group and his studies?

A. Goldman?

Q. Goldman.

A. Not off the top of my head.

Q. You're familiar with Compito, C-O-M-P-I-T-O, Dr. Compito?

A. Not off the top of my head.

Q. And you're not familiar off the top of your head with Dr. Goldman?

A. No.

Q. You're not familiar with the report by Dr. Goldman that showed that patients younger than 70 years had greater range of motion than older patients?

A. Was that in fractures or for arthritis?

Q. Fractures.

A. I don't recall the details, no.

Q. You would agree that in terms of performing a secondary surgery on a failed hemiarthroplasty, that the results in terms of going back in and doing further surgery are better when the surgery is performed within two weeks versus delayed?

A. I would say the earlier you do it, the better your success rate. I'm not sure there is any magic about two weeks. If it's 12 days or 16 days, I'm not sure if there is any difference right there. But, clearly, the earlier you do it, the better chance you have of having a better result. But that result would still always be less than you would have gotten after a primary procedure.

Q. You would certainly agree, would you not, that careful placement of the prosthesis and secure reattachment of the greater tuberosity to the shaft reduces the chances of complications following surgery?

A. Yes.

Q. And good to excellent results in terms of range of motion and pain relief can be expected in most patients, correct?

A. Well, it depends how you define good and excellent results.

Q. How do you define it?

A. I think you have to define it differently for different diagnostic groups. I think as a group, patients with fractures do not do as well as patients who are having hemiarthroplasties for arthritic conditions. I think that they do better than other traditional methods that were used before replacements came along, but they're certainly not as good as we would like them to be.

Q. Are there any studies that you are aware of that you've participated in, presentations that you've heard of, or anything out there in the medical world that suggests that reoperation or secondary surgery following a failed hemiarthroplasty always results in less than what you expected to achieve from the primary repair?

A. I can't quote you any references off the top of my head.

Q. In your report I believe you opined that results of reoperation are always less than those following primary procedures. Correct?

A. Yes.

Q. But you can't give me any particular

studies that support that position, can you?

A. Not off the top of my head, no.

Q. Can we agree that there are circumstances where reoperation is an appropriate option, even if not as good as the primary procedure?

A. Yes, we do that all the time.

Q. And if in fact reoperation is an appropriate option, even if not as good as the primary procedure, a patient is entitled to the benefit of having that reoperation, correct?

A. If the operation is indicated.

Q. Absolutely. Do you have a copy of the American Shoulder and Elbow Surgeons evaluation form?

A. Here with me today?

Q. Yes.

A. No.

Q. Do you use that in your practice?

A. Sometimes.

Q. What is meant when it states that a slightly performed prosthesis was done?

A. I think that's a typographical error. It doesn't mean anything to me.

Q. When, in your opinion, Doctor, did Mrs. Dunham tear her rotator cuff?

A. It is difficult to say. I don't know

specifically when or in fact if she actually tore it or it became dysfunctional.

Q. Do you intend to take the stand and testify to a reasonable degree of medical probability as to what stage of her recuperation she most likely tore the rotator cuff?

A. You mean as to a specific date?

Q. Or a specific time in the convalescence?

A. I can't get very specific, but in generalities, yes.

Q. What are the generalities that you can provide?

A. I think it was probably sometime six months, maybe longer, from after her surgery. So we're talking late spring, summer, somewhere in there, it ceased to function as it had been.

Q. And what was it that caused it to cease *to* function in that manner?

A. She may have torn it, or it may have ceased to function just because it was no longer able to bear up to the loads that were being subjected to it. I suspect that due to her age, her rotator cuff was not normal to begin with before she had the accident. It clearly got severely injured and damaged because of the accident. And while repaired,

sometimes rotator cuffs just don't hold up. Sometimes they're like tissue paper, and they might stretch out and thin out, Sometimes they become like wet tissue paper, just crumbles away, ceases to function. Sometimes it just tears completely.

Q. If there is evidence of avulsion of the greater tuberosity, how would that impact the rotator cuff?

A. Well, I think when we're talking about avulsion of the tuberosity, we're really talking about avulsion of the rotator cuff tendons, which are generally attached to the tuberosity or some fragment of the tuberosity. So if those are avulsed, the rotator cuff is no longer attached to the humeral bone, then the patient loses all ability, basically, to lift their arm up. The shoulder itself also may become unstable. The prosthesis may ride high up against the face of the glenoid, and the patient may have pain.

Q. Is there a cause/effect relationship between a disruption of the rotation cuff and an avulsion of the greater tuberosity?

A. I'm not sure I understand the question.

Q. Does an avulsion of the greater tuberosity lead to disruption of the rotator cuff?

A. If that piece of tuberosity that gets avulsed has a major part of the cuff on it, yes.

Q. So if there is an avulsion of a significant portion of the greater tuberosity, do you have to be concerned about an associated rotator cuff injury as well?

A. Again, I think we're talking about the same thing. But if you say there's an avulsion, the clinically important thing is has the rotator cuff become detached from the humerus. And sometimes it may tear off with a piece of bone. Sometimes it may not tear off with a piece of bone. Sometimes it may tear elsewhere. It may stay attached where you fix it, but it may give somewhere else. The important point is it is no longer connected in a functional way to the proximal humerus.

Q. Would you agree that if there is an avulsion of a significant portion of the greater tuberosity, there is an increased likelihood that there will be disruption of the rotator cuff as well?

A. I think it depends if you have the cuff attached to the bone and you secured the bone tuberosity piece to the humeral shaft or if you secured the actual tendon pieces to the humeral shaft and not the bone.

Q. Can you tell from Dr. Ghanma's surgery which he did?

A. He did a bone-to-bone reattachment,

Q. Now, taking that into account, if you have an avulsion of a significant portion of the greater tuberosity, is that likely to lead to disruption of the rotator cuff?

A. If that's the piece that had the rotator cuff attached to it, yes.

Q. Is that something that you need to be aware of as a potential complication, either at the time that the avulsion is discovered or in the ensuing weeks or months thereafter?

A. Yes.

Q. So it's foreseeable, if in fact that's the area where the rotator cuff was attached, that if you discover an avulsion of the greater tuberosity down the road, you are going to develop a disruption of the rotator cuff as well?

A. It's a possibility.

Q. Now, there is no evidence in this case that Mrs. Dunham had a shredded rotator cuff at the time of Dr. Ghanma's surgery, is there?

A. Well, again, you may be arguing semantics and descriptive terms. It depends what you mean by

shredded.

Q. Do you see anything that evidences -- how would you describe a shredded rotator cuff?

A. Tears with ends that are frayed loose, torn off from bone,

Q. And do you see any evidence that she had a shredded rotator cuff at the time of her surgery?

A. Under my description, that's usually what it looks like, yes.

Q. But does that automatically mean that the patient is going to have a bad functional outcome if the procedure is done properly?

A. No, it does not automatically mean that.

Q. When you do a surgery, a hemiarthroplasty on a patient in their 60s or 70s, you expect to have some osteoporosis, correct?

A. It's very common, yes.

Q. Is there anything about Mrs. Dunham's pre-surgical medical history that in any way decreased the likelihood of her having a good or acceptable functional outcome after the surgery?

A. I would say she had significant osteoporosis for a 66-year-old lady.

Q. On what do you base that?

A. I base that on two things. Number one,

just looking at the x-ray, you can see that her bones are very osteoporotic. Number two, she has a number of spine x-rays through the years that document osteoporosis going back when she was in her early 50s and probably more than what one would expect for the average 50-year-old.

Q. How did that impact the functional outcome that you would expect following a successful hemiarthroplasty?

A. Number one, being as osteoporotic, that probably contributed to the severity of the injury or the fact that the injury occurred at all. Number two, with weak, thin bones, repairs don't always hold up. Also, given her age, she probably had some pre-existing rotator cuff disease, even though she may have been asymptomatic. But the vast majority of patients, once they get in their 60s, have degenerative changes in their rotator cuff that you wouldn't find if they were in their 20s or 30s.

Q. Any evidence of prior shoulder injury or rotator cuff injury that you're aware of from your review in this case?

A. No. Again, I'm talking about part of the normal aging process.

Q. I'm talking about anything more than what

you would expect from the normal aging process.

A. No evidence of that, although the normal aging process could be highly variable.

Q. But, again, with Nancy Dunham's case, is there something that you say that she had increased likelihood of having less than optimal functional outcome because of her underlying medical condition, other than what you said about the osteoporosis?

A. No.

Q. And certainly if secondary surgery was an option because of hypothetically discovering a significant portion of the greater tuberosity avulsing, is there anything about her medical condition that would prevent one from pursuing secondary surgery on her?

A. I don't see in the records any contraindications to her having surgery.

Q. Okay. Now, according to the records, can we agree that the first time that surgery was recommended by Dr. Ghanma was not until February of 1996?

A. No.

Q. You believe Dr. Ghanma recommended surgery to her at some time before February of '96?

A. Let me stand corrected. The first time

that he recommended surgery to her was February of '96.

MR. TRAVIS: In the records.

THE WITNESS: In the records.

BY MR. MISHKIND:

Q. And he recommended -- what type of surgery did he recommend at that time?

A. A shoulder fusion.

Q. That would be an arthrodesis, correct?

A. Yes.

Q. One year out or a year plus two or three months out following this surgery, what would you have recommended?

A. In her case, based on my review of the records, not having seen her, I think that's a reasonable option if she was having significant disabling pain.

Q. Arthrodesis would only serve to reduce the pain. It certainly would not increase the range of motion, would it?

A. It can improve the range of motion in terms of elevation, but will limit motion in terms of rotation.

Q. Dr. Brems in his letter to Dr. Ghanma notes in the x-rays that he reviewed that he saw that

the greater tuberosity was displaced and was well above the humeral head. You've had a chance to look at those films, correct?

A. Yes.

Q. Do you agree or disagree with Dr. Brems?

A. I don't agree with that statement if he's basing that on the films that he took or that he reviewed on December 11, 1998 -- I'm sorry, 1996. When I review them, I cannot see that piece on those x-rays. But certainly other films earlier do show a piece up there, as we discussed before.

Q. And which films earlier show the greater tuberosity? Those are the ones back in January and -- in January of 1995, correct?

A. Yes.

Q. And would you agree with his statement that with displacement of the tuberosity for a long time, that marked scarring and complete dysfunction of her superior -- there's a word missing here -- superior and probably posterior rotator cuff occurred?

A. I would agree with that.

Q. Dr. Brems further says in his report that I would be a bit reluctant to recommend a shoulder arthrodesis as it would not only be difficult

technically in the absence of a humeral head, but my experience has been that it transfers pain from the arm into the shoulder blade, particularly in thin females such as this. Would you disagree with that statement?

A. I would disagree with that.

Q. Why is that?

A. That's not been my experience in terms of transferring pain to the shoulder blade in thin females. I think that the indication for doing arthrodesis would be severe disabling pain, and an arthrodesis is very good in terms of relieving that pain. They may not get 100 percent pain relief, but by and large, they are better off afterwards than they were before.

Q. If in fact the x-rays in January -- January 3rd, January 10th -- show a significant portion of the greater tuberosity having avulsed and the patient is in significant discomfort, would you agree that while not guaranteeing a more successful result, certainly it would have been an acceptable method to go back in and do a secondary surgery to treat the failed surgery of the shoulder?

MR. TRAVIS: Objection --

THE WITNESS: Are you talking about this

case?

BY MR. MISHKIND:

Q. Yes.

A. I would disagree. I don't find any indication for any surgical intervention in January of 1995.

Q. Why?

A. Clinically, she was improving her motion, having less pain, and she was doing as expected. There was no indication at that time to perform any surgery. Again, you have to correlate clinical findings with the x-ray. We treat patients. We don't treat x-rays. And based on the clinical records, she -- and plus the x-rays, she did not have a complete avulsion of her rotator cuff. Again, the humeral head was not high rising against the face of the glenoid, and there's documentation from a number of sources that she was continuing to make the expected clinical improvements.

Q. What are those sources, Doctor?

A. Dr. Ghanma's notes, the physical therapy, and one visit she had to Dr. Viswanath.

Q. When was that visit?

A. January '95, I think about the middle of the month.

Q. And who is he, what type of doctor?

A. I get the impression that it's her family doctor, general medical doctor. She went to see him complaining of hives. It was January 13th, '95.

Q. And what significance do you put on that note?

A. He makes the comment in the note here: She's doing pretty good on that, except that she has been complaining of recurrence of her hives.

The preceding sentence says: She had a broken shoulder and arm and has been operated on by Dr. Ghanma. She's doing pretty good on that, except that she has been complaining of recurrence of her hives.

Q. And you give credence to that statement by the doctor that she's doing pretty good with that when he's not the one that operated on her and she goes to see him for hives?

A. I would assume that he's putting down there what the patient told him in terms of how she was doing. We also have the records of the physical therapist in terms of how she's doing, and we have Dr. Ghanma's notes.

(The proceedings were interrupted.)

(Off-the-record conference.)

BY MR. MISHKIND:

Q. You read Dr. Kay's deposition, correct?

A. Yes.

Q. And you saw when Mr. Travis asked him to interpret the January 10, '95, film, his indication was that the film showed fragments of bone superior to the humeral head below the acromion representing a large portion of the greater tuberosity. The greater tuberosity is not in its initial attachment site where it should be.

Do you recall essentially that testimony by Dr. Kay?

A. Yes.

Q. Do you agree or disagree with his interpretation?

A. I agree with the fact that there's a piece of bone up there. I disagree with the fact that it is necessarily the major portion of the rotator cuff attachment.

Q. And can we agree that if in fact it is the major portion of the greater tuberosity, that coupled with what you state in terms of the clinical facts would be an important element in terms of whether or not to recommend secondary surgery or to treat this patient conservatively?

A. I'm not sure I understand the question.

Q. Doesn't it really boil down to Dr. Kay says in looking at the films of January 3rd and January 10th that what he sees represents a large portion of the greater tuberosity; what you see, you feel, does not represent a large portion of the greater tuberosity, that's number one. Can we agree with that?

A. Yes.

Q. Can we further agree that if what is seen in January does represent a large portion of the greater tuberosity, that has clinical significance in terms of whether or not you need to start thinking about secondary surgery at that point? Can we agree with that as well?

A. No, I wouldn't agree with that, because you have to determine if there is clinical significance of that x-ray finding. So you have to again go back to the patient, are there signs and symptoms that correlate with that, because the two have to correlate. In this particular case, they don't correlate. Clinically, she didn't have any evidence of having disrupted her rotator cuff at that time or a major portion of the greater tuberosity that contain the rotator cuff. So the two don't

correlate, and I don't see any indication at that time that there was to even consider surgery or to discuss surgery.

Q. Would you agree that if the greater tuberosity is detected to have shifted during the first two or three weeks, it would be a good idea to go back in and operate if you feel you can get adequate fixation for the patient?

A. If the patient has clinical evidence that it has shifted and detached, then, yes, you'd want to go reattach. But that's not the case here.

MR. TRAVIS: Would you read that question and answer back?

(The Court Reporter read the question commencing on page 78, line 15, and the answer concluding on page 78, line 11.)

BY MR. MISHKIND:

Q. On January 3, the first of those two films that we've been spending a lot of time talking about, is there any evidence of migration of the tuberosity?

A. There is a piece of bone in the subacromial space above the humeral head that does not appear to be there on the previous film of December 18, '94, talking about the film of January

3rd of '95, and it appears to be unchanged on the film of January 10, '95.

Q. But going back to my question, on January 3, does there appear to be any evidence of migration of the tuberosity from what was evident before January 3?

A. Taking the clinical picture and the x-ray into account, there does not appear to be migration of the rotator cuff or the tuberosity piece of bone that it's attached to.

Q. Does there appear to be any migration of the tuberosity from a radiological standpoint?

A. Again, there's a piece of bone in the subacromial space above the humeral head on the film of January 3rd, '95, that was not there on the film of December 18, '94. On those films of January of '95, though, you do see other pieces of tuberosity still attached where they were put back.

Q. Do you have any explanation for why on January 3 you see that portion of the tuberosity, whereas you didn't see it on the previous film?

A. Again, as Ghanma mentions, there were a lot of small, loose, broken pieces, and it could have migrated, moved, because the patient is moving, so things get pushed around and moved around.

Q. Could you state that based upon her pre-operative osteoporosis that Mrs. Dunham was likely down the road to develop problems where her greater tuberosity would not heal? Do you follow my question?

A. Not really.

Q. Okay. Not knowing what happened, but knowing what the patient's pre-operative and intraoperative condition was, could you state to a reasonable degree of probability that down the road it was likely that her greater tuberosity would probably not heal or that she had a likelihood of not healing?

A. You're talking about developing a malunion as opposed to the tuberosity pulling off?

Q. Tuberosity pulling off, malunion, or nonunion. Just to put it in proper context, could one say -- without having a crystal ball, could one say at the time of the operation that because of this patient's osteoporosis, it's more likely than not down the road she was likely to have the greater tuberosity avulse or the greater tuberosity have a malunion or a nonunion, or would that just not be something that one could state to a reasonable degree of probability?

A. I think to a reasonable degree of probability or medical certainty, patients with osteoporosis are going to have more problems in terms of getting things to heal or heal in a satisfactory position than those people that do not have osteoporosis.

Q. And I appreciate that, but can you state to a probability before doing this hemiarthroplasty that it was likely that she was not going to heal because of her osteoporosis?

A. In her specific case?

Q. Yes.

A. I don't think you can say that at all.

Q. Okay. She had some type of hypothyroidism, correct?

A. Yes.

Q. Was that in any way a factor that made her a poor surgical risk, in your opinion?

A. No.

Q. When is the last time that you know of that Dr. Ghanma performed any x-rays to assess the status of her -- the anatomical position of her shoulder?

A. The last set of x-rays she got in the immediate post-operative period was March 7th, '95.

Q. And then he continued to see her through August of 1995, correct?

A. Correct.

Q. So between March and August, there are no further x-rays to look at to see what the status is of the greater tuberosity and the surrounding structures, correct?

A. Correct.

Q. Do you have any explanation for why no further x-rays were taken during that period of time?

A. I don't see any clinical indication for it. I think that by the March visit, she had healed. And unless there's a specific clinical indication, I don't think you're obliged to have to get x-rays at every visit. There's no indication for it.

Q. If the greater -- a significant portion of the greater tuberosity had avulsed in January of 1995 and if her clinical status was such that a reasonable and prudent orthopedic surgeon would have considered going back in and doing secondary surgery, would she have been, from a medical standpoint, an appropriate candidate for surgery?

A. Again, as you asked before, I don't see any contraindication to surgery at any time either in December, January, February, March, or down the road.

Q. And can we agree again with the hypothetical that we are dealing with the greater tuberosity avulsing -- and it's not just a small portion, but a substantial portion of the greater tuberosity -- and her clinical symptoms were such that a reasonable and prudent orthopedic surgeon would have entertained secondary surgery, would you agree with me that Mrs. Dunham would have had a better chance to achieve a shoulder with less pain and a shoulder with greater range of motion than if she were treated nonsurgically?

MR. TRAVIS: Objection.

THE WITNESS: There are a lot of hypotheticals in there that don't apply to this case, so you lost me.

BY MR. MISHKIND:

Q. Again, they may or may not apply. These are fact questions. I understand your interpretation, what you see in the films. We agree, can we not, that you and Dr. Kay do not see eye to eye in connection with this case in terms of the interpretation of the films and what should have been done?

A. It's not just the films. It's the films and taking the patient's clinical status into

account. We obviously have a difference of opinion. He seems to want to just read the x-rays, and I think it's important to look at the x-rays and the patient. As I said, we treat patients. We don't treat x-rays.

Q. You may or may not be correct with that, but can we agree that you and Dr. Kay in reviewing this case intellectually come to different opinions?

A. Obviously.

Q. And your conclusion is that surgery was not warranted in January of 1995, and his was that it was warranted?

A. Correct.

Q. And what I'm saying to you is, hypothetically, if the circumstances were such that you were saying that this is a substantial portion of the greater tuberosity, it has avulsed, and that clinically the patient was an appropriate candidate to have at least had consideration for secondary surgery, under that hypothetical -- I know you disagree with the facts -- but under that hypothetical, would you agree Mrs. Dunham would have had a greater chance to have achieved a shoulder with less pain and a shoulder with greater range of motion by having the surgery as opposed to being treated conservatively?

MR. TRAVIS: Objection to the hypothetical which says nothing about her clinical pain situation. You can answer.

THE WITNESS: Again, I'm not sure you can answer that, because in her case here, at the time we're talking about, she was having less pain, improving her motion, and clinically doing well. So I find it hard to imagine how you could improve upon that when she's doing well and fully following her expected clinical course. Any time you reoperate, whatever factors were responsible for things failing the first time are still there. So you still have a chance at things failing, not doing well. Whatever happened the first time can happen the second time. Anytime you go back early on, anytime you go back anytime, but particularly early on, you have increased risk of complications.

BY MR. MISHKIND:

Q. I understand that there are risks and complications. But can we agree that weighing and balancing the risks and complications, if a decision is made that secondary surgery is warranted, that the chance of the patient achieving a shoulder on a permanent basis that would have less pain and have greater range of motion would be increased by going

back in and doing a secondary repair as opposed to treating the patient nonsurgically?

MR. TRAVIS: Objection to the hypothetical. You can answer if you can, Doctor.

THE WITNESS: If you're talking about a purely hypothetical situation where it looks like the major portion pulled off and clinically they cannot elevate their arm at all and they have pain, so you're convinced the cuff is not attached, then, yes, you do have a better chance of it attaching and staying attached if you go back and operate and put it there. Because if it truly has detached and it is a significant distance away from where it's supposed to be so it's not going to heal, then it's never going to heal there on its own, and the only way to get it back there to give it a chance to heal would be with an operation. But, once again, whatever circumstances and causes were present initially for that to happen are still there the second time.

BY MR. MISHKIND:

Q. But weighing and balancing going in and doing surgery versus doing nothing, the patient would have a better likelihood of a good outcome by going in and doing surgery as opposed to doing nothing for the patient, given that hypothetical?

A. In the hypothetical I just outlined, they would have a better chance. Doesn't mean they would have a better result, but they would have a better chance.

Q. Doctor, you state in reading Mrs. Dunham's or the Dunhams' depositions: Little help, patient recollection often inaccurate.

What is it that you mean when you state that the deposition is of little help?

MR. TRAVIS: Objection to your interpretation of what he meant by that. You can answer. And if you can you show him --

BY MR. MISHKIND:

Q. It says: Dunham deposition little help, patient recollection often inaccurate.

That's all you marked down in the Dunham deposition. I'd like to know what it is about the Dunham deposition that warranted a two-line statement and is of little help to you in terms of coming to the truth in this case.

A. It didn't provide me with any significant fact information to change my opinion.

Q. Were questions asked sufficient enough so you could understand what the subjective symptoms and the progress of the patient was between December when

the surgery was done and the end of August of '95 when she was initially told to come back in three to four months or essentially discharged from active treatment?

A. I felt the questions were adequate, yes.

Q. Tell me what you learned from your review of the deposition as to what Mrs. Dunham said about the level of pain that she was having and the functionality of her shoulder during that period.

A. Based on her deposition, she was having increased amounts of pain and decreased function that contradicts what's in the medical records.

Q. And you would agree that Dr. Ghanma claims that he discussed the option of surgery with Mrs. Dunham, even though it wasn't something that he was recommending, that he discussed that with her sometime in January of 1995, correct?

A. I think that he mentioned -- my interpretation is that he mentioned the finding on the x-ray, and that that could potentially become something in the future that they might have to reoperate on.

Q. Do you recall from reading Dr. Ghanma's deposition that he did in fact discuss with Mrs. Dunham in January of 1995 the option of surgery,

but he did not feel, nor did he recommend to her at that time, that surgery was an appropriate option?

A. Yes, I believe he mentioned that to her.

Q. Yet there's nothing in his office records that is consistent with that testimony, is there?

A. That's correct.

Q. You've chosen to believe Dr. Ghanma over Mrs. Dunham; is that correct?

MR. TRAVIS: Objection. You can answer.

THE WITNESS: I didn't say that.

BY MR. MISHKIND:

Q. Dr. Ghanma's testimony is inconsistent with what he has in his records?

A. It's not inconsistent. It's just not well-documented in his records. There's nothing that's inconsistent about it or contradicts it.

Q. Is there anything that you believe Mrs. Dunham did that caused or contributed to the failed hemiarthroplasty?

A. No, nothing specifically, no.

Q. If a shoulder hemiarthroplasty is performed and the results are successful or what you consider to be within successful ranges for the treatment of a fracture, three- or four-part fracture, what do you consider to be acceptable range

of motion following such a surgery?

A. Oh, I think that varies from patient to patient. I think it depends on their age, occupation, their goals, their expectations.

Q. Let's deal with Mrs. Dunham. Given her age, her medical history, the type of fracture she suffered, based upon your experience and the studies, whether they're Neer studies or anyone else's that you follow, what do you believe to be an acceptable range of motion following successful hemiarthroplasty?

A. If they can get their arm up to at least shoulder level or above and if they can turn their arm out, or what we call externally rotate, about 30 degrees, I think that will allow them to carry out most activities of daily living.

Q. So you're talking about up to shoulder level, that's 90 degrees?

A. Yes.

Q. And there are studies -- Neer, I think goes as high as 115 or 120 degrees of active elevation?

A. You mean in terms of his results?

Q. Right, or as to what he considers to be acceptable range of motion following successful

hemiarthroplasty.

A. I'd have to go back and check and see if that's what Neer considers to be acceptable.

Q. Would you agree, though, that anywhere between 90 and somewhere in the low 100s is an acceptable range of motion, depending on whose study you look at?

A. I think that's what we'd like to aim for, and if you achieve that, the patient will be able to carry out most daily activities and would have what we would call a satisfactory result.

Q. And you're not able to cite me to any studies that would permit you to say, if secondary repair is necessary within a short period of time after the failed primary repair, how much lower that active range of motion would be, are you?

A. Correct.

Q. What is your understanding as to her active range of motion now, based upon your review of the records?

A. The last office note by Ghanma in February of '96 said that she had elevation or what he called forward flexion of 35 to 40 degrees, and the evaluations by Dr. Brems in December of '96 would agree with that -- I'm sorry, January of '97, would

agree with that.

Q. Would you have any reason to believe that her range of motion would likely be significantly different today, based upon what you have in these two landmarks?

A. No, I would expect it to be very similar.

Q. And with that degree of range of motion, does that impact one's ability to do activities of daily living?

A. Yes.

Q. And what kind of activities of daily living are restricted as a consequence of that limitation?

A. Well, she'll have trouble doing anything at shoulder height since she cannot actively get her arm up there. My understanding is she can passively put it up there, and if she does that, then she can carry out some things. Patients learn to adapt in various ways to various limitations, So without evaluating her specifically, it would be hard to say specifically what daily activities she's not able to do, because, again, sometimes they may miss the active part, but can do it passively. So one hand helps the other up, and they manage.

Q. We can certainly agree that 40 degrees of

range of motion is not considered a good outcome following a hemiarthroplasty, correct?

A. In terms of motion, that's correct.

Q. And certainly the patient continues to experience, at least from what you have reviewed, pain on a daily basis, correct?

A. She has pain, but it's hard to -- you know, pain is such a subjective thing. It's hard to quantitate. The only guide I have here is in Dr. Brems' note when he says, because the patient is taking so little Darvocet, to me, that means she's not having that much significant pain that she's requiring heavy-duty narcotics all the time for the shoulder. But, again, it's a very subjective thing, and I don't see any objective evaluation of her pain anywhere in the notes.

Q. When you talk about the clinical status of the patient, part of that clinical status of the patient involves subjective statements by the patient as well as objective findings, correct?

A. Yes.

Q. And when you read over Mrs. Dunham's deposition, what did you learn relative to the degree of pain that she's experiencing as of 1998 or 1999?

A. To her, she's experiencing a great deal

of pain or a fair amount of pain. And that seems to be in conflict with some of the records that I've reviewed.

Q. Are you suggesting that Mrs. Dunham is being less than candid in her statements of her pain?

A. No.

Q. Why do you mention that they are in conflict?

A. A couple of things. I think early on, you've got the records of Dr. Ghanma, you've got the physical therapist, and you've got that one mentioned note by her GP about how she's doing, and you get a certain impression which is at odds with how she describes the way she was. And then subsequent to that, she's taking a lot of Darvocet, but some of that appears to be for her back and not for her shoulder. But she has the impressions for her shoulder and not her back. But there is documentation she's been given Darvocet for her back, and she has a long history of back problems.

Q. Doctor, can we agree that there's nothing in the records that Dr. Ghanma ever discussed with Mrs. Dunham the option of going back in and doing further surgery at any time in 1995?

A. In his records, that's correct.

Q. And are you able -- looking at the office records of Dr. Ghanma or the physical therapy records, are you able to identify a month where you believe more likely than not she developed evidence of a failed hemiarthroplasty?

A. What do you mean by failed hemiarthroplasty?

Q. Disruption of or avulsion of the greater tuberosity.

A. Again, as I've said, I think that her rotator cuff at some point down the road became dysfunctional and may or may not have torn. I think it was probably a slow process over time as opposed to a sudden event, but it's hard to say with any certainty when that occurred.

Q. Okay. Dr. Kay has testified that when she avulsed her greater tuberosity in January of 1995, that is when she had the rotator cuff tear. Do you disagree with Dr. Kay?

A. Yes.

Q. Dr. Kay is also of the opinion that while there is no guarantee that she would have had a successful outcome from a secondary surgery, he feels to a probability she would have had a dramatically better shoulder had she undergone a repeat operation.

Do you agree or disagree with him?

A. I disagree with that.

Q. And the reason being?

A. There is no basis of foundation. I think he gave numbers *of* 80 percent improvement in pain relief and 50 percent improvement in function. There is just no basis that I know of for that, and it's not been my clinical experience.

Q. If she had had a secondary surgery to treat an avulsion of the greater tuberosity and a rotator cuff disruption, would you agree that she would have had a 50/50 chance of receiving a good outcome?

A. Again, it depends how you define good outcome. But if in fact she had disruption of her rotator cuff at that time, which obviously I don't think she had, to go back and operate on her would have given her a better chance at having improved outcome compared to not doing it, as we've talked about.

Q. Do you have any criticism of what was done by the physical therapist in the treatment of Nancy Dunham?

A. No.

Q. What I'd like you to do, Doctor, so that

I don't have to strain my eyes in reading this, is I'm going to have you read the back of plaintiff's exhibit 2, which is the notes on Dr. Ghanma's depo. Read them slowly into the record for the benefit of me and, more importantly, the court reporter. And then after that, I'm going to have you read your notes on Dr. Kay's deposition. Okay?

A. Sure. This will be with reference to Dr. Ghanma's deposition.

Page 63, double shadow is not equal to loosening, is a radiosclerotic line of no significant consequence. Rotator cuff can fail, even if repair held up, because tissue is damaged in fracture and bone osteoporotic and patient old and cuff already worn because of age. Therefore, reoperating will not help the situation.

I have a note off to the side: Check immediate post-op x-ray versus film of 1-3 and 1-10-95.

Q. Let me interrupt you for one second and ask you a question about that. You said reoperation would not help the situation. You're not saying in 100 percent of the cases, because of what you believe to be an old patient with the injury and her osteoporosis, that reoperation would be doomed to

failure, are you?

A. No, it's just if they didn't have a rotator cuff.

Q. Okay.

A. Again, these are notes that I jot down as I'm going along. I wouldn't take it as fact. I may put something down that I find was wrong later or may state something that I change my mind about later. So, again, I wouldn't --

Q. No, I'm just asking you --

A. -- wouldn't put a lot of weight to this.

Q. I'm just asking you questions as we go through this so I won't have to wait until the end.

A. Okay. And, again, I may put something down that I changed my mind about as I read more and find out more. So if it's at odds with what's in the letter, I think what's in the letter is what ought to be taken as my opinions.

Q. Well, in all fairness, what you say in totality are your opinions, whether they're in the letter or whether they're subject to cross-examination. So that's why I'm asking you.

A. But, again, if I write something down here as I'm going through it and I've got questions or misunderstand something that becomes more clear

later, I may have a complete different opinion by the time I'm done.

Q. Are you suggesting on the record that you've changed your opinions as you've got through this case?

A. No, I think my opinions are stated in the letter of --

Q. March 17?

A. -- March 17, 1999.

Q. In that letter you indicated that you reviewed the medical records and x-rays sent, correct?

A. Correct.

Q. You didn't mention anything about the depositions, having reviewed them. I take it you didn't review them for purposes of your letter?

A. I have reviewed the depositions. They come under records.

Q. So medical records should really be -- to make this accurate, medical records should be medical records and depositions?

A. If you'd like. I consider them all part of the same thing.

Q. You consider the deposition testimony to be medical records?

A. Part of the records that were sent to me.

Q. Okay. Go ahead, Doctor.

A. Page 70, injury may not necessarily be anything she remembers or had immediate reaction to. Patients can tear rotator cuff months after surgery. May not be aware of it and can lead to poor result. Surgery often not successful because cuff gone or irreparable. Page 82, if reoperate, do for pain, not function. Patient wasn't having severe pain to warrant reoperation. Page 84, can get proximal migration without tear, can be due to dysfunction. Page 87, by March, three months post-op, all healed, and, therefore, don't necessarily need any more x-rays unless specific clinical indication.

Q. Let me stop you for one second and ask you a question. You're not of the opinion that at the time of the surgery, the hemiarthroplasty, that her rotator cuff was gone, are you?

A. No.

Q. You acknowledge that at some time after the surgery, there is a disruption or a tear to the rotator cuff?

A. Or dysfunction, yes.

Q. Which may be a combination of some underlying conditions as well as a disruption that

ensued following the surgery?

A. As well as injury from the time of the fracture, yes.

Q. But as to when that occurred, you're not able to give me to a reasonable degree of probability a time period that you'll be able to testify to at trial, correct?

A. Not with any certainty, that's correct.

Q. Okay. Go ahead, Doctor.

A. Page 98, surgery not successful, but not due to negligence, malpractice, or deviation.

Q. So there's no question that this was a failed surgery on the part of the doctor. It's just that you're going to take the stand and say that this failed surgery was not due to any negligence on his part?

A. Correct.

Q. Does that conclude your comments on Dr. Ghanma's deposition?

A. Yes.

Q. And we've already talked about the two lines in terms of what you said about Mrs. Dunham's or the Dunhams' depositions, correct?

A. Yes.

Q. Next you have Dr. Kay's comments?

A. Comments on Dr. Kay's deposition, yes. Page 26, difference between three- and four-part fractures can be significant regarding treatment and outcome. Page 27, AVN do better because --

Q. Wait, what was that?

A. AVN, avascular necrosis --

Q. Okay.

A. -- do better because the cuff is normal, tuberosities are not fractured off. Status of tuberosities and cuff most significant factors affecting outcome. Page 29, younger patients do better because better bone quality and better cuff tissue. 31, x-rays could be normal, but patient has osteoporosis. Therefore, need other tests. See osteoporosis on plain x-rays. Therefore, don't need other tests.

Q. There weren't any other tests that had been done to demonstrate osteoporosis at any time prior -- in her shoulder area prior to her surgery, are there?

A. She had a number of x-rays done that demonstrated osteoporosis. I don't believe she had a bone densitometry.

Q. Nothing in the shoulder, correct?

A. Correct. The shoulder is not a typical

place you measure for osteoporosis, by the way. Page 39, reoperating with poor cuff tissue would not make her better. The point is that results vary greatly in clinical judgment, not simple as tuberosity is pulled off and just reattach them. Usually other problems and more complicated. And same reasons for failure first time, i.e., poor bone, poor cuff still exist.

Q. Doctor, as you're going through these, these are areas you're essentially taking issue with what Dr. Kay said in his deposition, correct?

A. Yes, or just commenting on them.

Q. But mostly it seems like these comments are areas where you disagree with what Dr. Kay has said, correct?

A. Yes. Page 40, tuberosities don't pull off, but cuff tissue attenuates and tears. Page 69, dramatizing, not relevant and excessive.

Q. What does that mean?

A. I'd have to go back and look what he was talking about.

Q. At page 69?

A. Yes.

Q. Okay.

A. Operating not without risks, not

necessarily -- something -- not necessarily something to improve her specific situation, and problems can arise, was a judgment call by Ghanma within standard. Page 70, patient's cuff not normal when she fell, aged and worn. Page 70, shredded is possible with this injury.

Q. I'm sorry, what was that?

A. Shredded, quotation marks, is possible with this injury. Cuff can get beaten up and is already non-normal. Page 78, we know what she ended up with. Ghanma didn't know result at time. He made a reasonable clinical judgment. Page 84, patient wasn't having significant pain at the time in question, therefore, what was he going to offer her. Functional increase much less than 50 percent. M.D. made a reasonable judgment call at the time. Just because it did not turn out correct, what that does, it does not equal negligence or deviation.

Q. You said functional increase much less than 50 percent?

A. Yes, referring to his comment that she could expect 50 percent functional improvement.

Q. And your opinion is that with secondary surgery, had that been something that a reasonable and prudent orthopedic surgery would have done, it's

likely that her functional improvement would have been less than 50 percent?

A. I think what I was saying there is at the time that we're talking about, she was making the expected improvements in pain and function and following an expected post-operative course, that I don't see what she was going to improve upon that she otherwise looked like she was getting from her continued post-operative treatment.

Q. Anything else in Dr. Kay's deposition that you felt significant enough in terms of taking issue with that you marked it down?

A. Nothing else that I wrote down.

Q. And is there anything else that you can think of, based upon your recent review of the deposition that you take issue with?

A. Not that we haven't already discussed.

Q. Anything that you otherwise take issue with in Dr. Kay's opinions other than what we have already discussed?

A. No.

Q. Have we covered all of the opinions that you hold in this case?

A. Yes.

Q. Do you intend to review any further

information or records or do any further research prior to flying up to the best location in the nation for purposes of this trial?

A. If Mr. Travis sends me something, I will surely review it. I don't plan on doing any independent reviews or research on my own.

Q. Give me just a second, Doctor, we may be done.

What's your understanding, Doctor, as to why Mrs. Dunham did not have an arthrodesis performed by Dr. Ghanma when she returned in February of 1996? You're looking to Dr. Ghanma's office records to answer this question?

A. I am looking at that. She obviously decided she didn't want to have it done.

Q. And do you recall the explanation given by the patient as to the reason she didn't have --

A. No.

Q. But in responding to that question, you first went to Dr. Ghanma's records and didn't go to her testimony, correct?

A. Correct.

Q. Do you find it unreasonable, on the patient's part, given the history that she had gone through, to decline having an arthrodesis in February

of 1996?

A. No.

Q. Do you still use the Constant Scoring System in assessing results following a hemiarthroplasty?

A. Sometimes I use the Constant Scoring, sometimes we use the American Shoulder & Elbow Surgeons. But we don't always do that every visit, every patient.

Q. And have you found that the results following total shoulder arthroplasty are still fairly consistent with the results of your article back in July of 1998 that you did with Dr. Hartsock?

A. That article didn't have anything to do with total shoulder arthroplasty.

Q. Shoulder hemiarthroplasty?

A. For fractures.

Q. For proximal humeral fractures, right. And you find that the results following proximal humeral fractures -- the hemiarthroplasties for proximal humeral fractures, that the results in terms of functional results and the results from pain are -- continue to be fairly consistent in practice and in what the literature shows?

MR. TRAVIS: Objection, if you understand

that question.

THE WITNESS: Again, that is more of a review article than any review of our specific patients. And I would say in the year since that was written, there has not been anything significantly different from what was known at the time that article was written.

MR. MISHKIND: No further questions, Doctor. Thank you.

THE WITNESS: Thank you.

(The witness, after having been advised of his right to read and sign this transcript, does not waive that right.)

(The deposition was concluded at 3:42 PM.)

SIGNATURE OF DEPONENT

I, the undersigned, RICHARD J. FRIEDMAN, M.D., do hereby certify that I have read the foregoing deposition and find it to be a true and accurate transcription of my testimony, with the following corrections, if any:

PAGE	LINE	CHANGE	REASON

_____
RICHARD J. FRIEDMAN, M.D. Date

CERTIFICATE OF REPORTER

I, Janice N. Shepherd, Certified Shorthand Reporter and Notary Public for the State of South Carolina at Large, do hereby certify:

That the foregoing deposition was taken before me on the date and at the time and location stated on page 1 of this transcript; that the witness was duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed by computer-aided transcription; that the foregoing deposition as typed is a true, accurate, and complete record of the testimony of the witness and of all objections made at the time of the examination.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 4th day of August, 1999, at Charleston, Charleston County, South Carolina.

Janice N. Shepherd,
Certified Shorthand Reporter
My Commission expires
October 31, 2004

I N D E X

REQUESTED INFORMATION INDEX

E X H I B I T S

(Original Exhibits Retained by Witness)

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February 4, 1999

Richard J. Friedman, M.D.
33 Rebellion Road
Charleston. SC 29407

FEDERAL EXPRESS

Re: Nancy Dunham, et al. v. Manhal Ghanma, M.D.
Case No. 97 CV 119540
Judge McGough
Our File #: 94418-101386

Dear Dr. Friedman:

Thank you for agreeing to review this case on behalf of our client. Dr. Manhal Ghanma with respect to the above-captioned matter.

I am enclosing for your review. a copy of the report from the plaintiff's expert. Dr. Kay. Also please find the following medical records of the plaintiff. Nancy Dunham:

1) Dr. Ghanma's Office Chart:
2) Elyria Memorial Hospital:
3) The Cleveland Clinic Foundation;
4) Dr. Viswanath:
5) Dr. Carandang: and
6) CVS Pharmacy.

Also please find in a separate envelope. a copy of Dr. Ghanma's x-ray films.

Your one hour retainer of $500 will be forwarded to you from Ohio Lnsurance Guaranty Association. After you have had the opportunity to review these records. please call me at 1-800-229-53 10 with your thoughts.

Received 2/8/99

Very truly yours.

D John Travis

DJT:pmd

Friedman
Exhibit 91
Date 7-13-99
L.W.R. & Assoc.

- 4 pt. ...

- Hemi - TSA 12/15/94 — Procedure indicated - progressing disease

- A/S + P - ... course correct

- Xrays - 1/3/95 - reported as ... → shows transition ... off

11/6/95 - transition displaced

3/96 → recommended fusion

- 12/96 - William consulted

- 1/97 - Burns consulted

Xrays

3 2

Clinically pt was progressing ...
... pain + ... Burns ... made a clinical judgment ... continue ... PT and not re-operate ... pt was getting better
(after ... 1/24, 2/7, 2/21, 2/7)

- if re-operate, ... risk of complications and no guarantee result would be any better

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D John Travis
Direct Dial: 216-522-1590

February 22, 1999

VIA FEDERAL EXPRESS
Richard J. Friedman, M.D.
33 Rebellion Road
Charleston, SC 29407

Re: Case: *Dunham, et al. v. Manhal Ghanma, M.D.*
Claim #: 105402
Our File #: 94418-101386

Dear Dr. Friedman:

Enclosed for your review are the following.

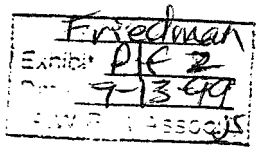
1. Deposition transcript of Dr. Ghanma.
2. Deposition transcript of Nancy Dunham: ana
3. Deposition transcript of Charles Dunham.

Thank you.

Very truly yours,

D John Travis

DJT:njm
Enclosures



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June 22, 1999

Richard J. Friedman, M.D.
33 Rebellion Road
Charleston, SC 29407

Re: Case: *Dunham, et al. v. Manhal Ghanma, M.D.*
Claim #: 105402
Our File #: 94418-101386

Dear Dr. Friedman:

Enciosed is a transcript of the deposition of Dr Kay

Please review this **and** call me at your earliest convenience.

Very truly yours.

D John Travis

DJT:njm
Enclosure

Friedman
Exhibit PF3
Date 1-13-99
A.W.R. & Assoc.